WHAT YOU NEED TO KNOW ABOUT HEALTH INSURANCE REFORM

The Affordable Health Care for America Act is about putting you and your doctor back in charge – not the insurance companies. It is designed to:

- **provide more stability and security for Americans who currently have health insurance,**
- **offer quality, affordable choices for those who don't, and**
- **rein in the cost of health care for families, businesses and the government**.

The need for reform is urgent. Our current health care system is simply unsustainable:

- Health care premiums are growing three times faster than wages.
- Last year, more than half of Americans postponed medical care or skipped their medications because they couldn't afford it.
- In the past three years, over 12 million Americans were discriminated against by insurance companies due to a pre-existing condition.

I. INSURANCE REFORMS AND CONSUMER PROTECTIONS

If you are among the hundreds of millions of Americans **who already have health insurance**, nothing in this plan will require you or your employer to change the coverage or doctor you have. What this plan will do for the millions of Americans with insurance is to provide you with more security and stability – making the insurance you have work better for you, with such reforms as the following:

- It will be against the law for insurance companies to deny you coverage because of a pre-existing condition.
- It will be against the law for insurance companies to drop your coverage when you get sick or water it down when you need it most.
- Insurance companies will no longer be able to place some arbitrary cap on the amount of coverage you can receive in a given year or a lifetime.
- A limit will be placed on how much you can be charged for out-of-pocket expenses, because no American should go broke because they get sick.
- Insurance companies will be required to cover, with no extra charge, routine checkups and preventive care, like mammograms and colonoscopies.

II. HEALTH INSURANCE EXCHANGE

If you are one of the tens of millions of Americans **who don't currently have health insurance**, this plan will finally provide you quality, affordable choices.

- The bill creates a new Health Insurance Exchange – a marketplace where those who lack access to affordable insurance through an employer, employees of small businesses, and the self-employed will be able to shop for health insurance at competitive prices, at large group rates.
- Insurance companies will have an incentive to participate in this Exchange because it lets them compete for millions of new customers.

- As one big group, these customers will have greater leverage to bargain with the insurance companies for better prices and quality coverage.
- The existence of this new Exchange means that if you lose your job, change your job, or strike out on your own to start a business, you will be able to get coverage.
- Over time, the Exchange will be opened to additional employers as another choice for covering their employees.

III. PUBLIC HEALTH INSURANCE OPTION

For those buying insurance in the Exchange, the bill provides an option of purchasing a public health insurance plan, in order to keep insurance companies honest, increase competition, and provide consumers more choices.

- The health insurance industry is increasingly consolidated. Currently, in the vast majority of states, the top two health insurers in the state control more than 50 percent of the market.
- The public option will operate on a level playing field with private insurers. Under the bill, like any private insurance company, the public option will have to be self-sufficient and rely on the premiums it collects.
- The public option can provide real competition to private insurers – forcing all insurance plans to be more efficient–because it can avoid some of the overhead that gets eaten up at private companies by profits, high administrative costs and executive salaries.
- The public option will keep pressure on private insurers to keep their policies affordable and treat their customers better.

IV. AFFORDABILITY

A primary focus of the bill is ensuring that health insurance policies will be affordable for America's families and small businesses.

AFFORDABILITY FOR INDIVIDUALS

- The bill ensures that the private insurance plans and the public insurance option that are available on the Exchange are affordable by providing Affordability Credits up front to individuals and families to reduce their share of their premiums – providing credits for individuals and families with incomes up to 400% of poverty [$88,200 for a family of four].
- The Affordability Credits will be provided on a sliding scale, such that premiums owed directly by the individual or family (not covered by the credit) will range from 3% of income at 150% of poverty up to 12% of income at 400% of poverty.
- In addition, the creation of the public insurance option itself will make insurance more affordable throughout the marketplace, with companies competing with a non-profit insurer.

AFFORDABILITY FOR SMALL BUSINESSES

- The bill creates a tax credit for small businesses to help them offer coverage to their employees, covering up to 50% of the employer's contribution for two years. Small businesses with 10 or fewer employees and with average wages of $20,000 or less will be able to claim the full credit amount. The credit phases out for businesses with more than 10 employees and average wages over $20,000, with a complete phase-out at 25 employees or average wages of $40,000.
- Additionally, small businesses will save money with access to the low rates large groups get, and no higher premiums if someone in their workforce gets sick.

V. SHARED RESPONSIBILITY

Fixing our health insurance system to ensure access to quality, affordable care for all Americans requires shared responsibility, on the part of individuals, employers and the government.

INDIVIDUAL RESPONSIBILITY

- Even if we provide affordable insurance options, there may be those who still want to take the risk and go without coverage. The problem is: such irresponsible behavior costs all the rest of us money. The average family of four pays more than $1,000 each year to support emergency care costs for 37 million uninsured Americans.
- Unless everyone does their part, meaning insurers can spread the risk over more people, many of the insurance reforms we seek – especially requiring insurance companies to cover pre-existing conditions – just can't be achieved.
- That's why, under this bill, individuals will be required to carry basic health insurance – just as most states require you to carry auto insurance. There will be a hardship waiver for those individuals who still cannot afford insurance.

EMPLOYER RESPONSIBILITY

- If some businesses don't provide workers health care, it forces the rest of us to pick up the tab when their workers get sick, and gives those businesses an unfair advantage over their competitors. That's why, under this bill, larger businesses will be required to either offer their workers health care coverage, or chip in to help cover the insurance costs of their workers.
- Under the bill, there is a recognition that providing health care coverage is unaffordable for many small businesses. Therefore, all businesses with payrolls of $500,000 or smaller – or 86 percent of America's businesses – will be exempt from these requirements, and their employees will have access to affordable plans through the Exchange and Affordability Credits to help pay for that coverage.

GOVERNMENT RESPONSIBILITY

- The government is responsible for ensuring that every American can afford quality insurance, through the new affordability credits, insurance reforms, consumer protections, and improvements to Medicare and Medicaid—and that the deficit is reduced in the process.

VI. ENSURING REFORM REDUCES THE DEFICIT

The Affordable Health Care for America Act is fully paid for. Indeed, the nonpartisan Congressional Budget Office estimates that the bill will reduce the deficit by $32 billion (without the CLASS Act) and by $104 billion (counting the CLASS Act) over the next 10 years.

TARGETING WASTE, FRAUD, AND INEFFICIENCY IN MEDICARE AND MEDICAID

About half of the bill's cost is paid for by targeting waste, fraud, and inefficiency in Medicare and Medicaid – mostly Medicare. Currently, billions of dollars are lost each year to waste and inefficiency in the Medicare system. The waste is driving up seniors' health care costs and threatening Medicare's long-term solvency. This bill strengthens Medicare by eliminating waste without cutting any Medicare benefits – extending the solvency of Medicare by five years and improving the quality of care. Some of ways that the bill targets inefficiency and waste in Medicare include:

- Saving over $150 billion by putting Medicare Advantage plans and traditional Medicare on a level playing field by eliminating overpayments to Medicare Advantage plans.
- Reducing over-billing by providers and cutting out duplicative paperwork and tests.
- Cracking down on abuse from those who fraudulently bill Medicare.
- Preventing dangerous hospital readmissions by providing follow-up care that will help individuals safely transition home after a hospital stay.

Many of the Medicare savings achieved are reinvested into improving benefits, including:

- Lowering seniors' Rx drug costs by phasing out the "donut hole" coverage gap.
- Eliminating copayments and deductibles for preventive care, such as mammograms.

A SURCHARGE ON MILLIONAIRES AND CERTAIN OTHER REVENUE RAISERS

Roughly the other half of the bill's cost will be paid for by a health care surcharge on millionaires (affecting only 0.3% of Americans) and certain other revenue raisers, which are relatively small.

- Under the bill, the top 0.3% wealthiest Americans would pay a surcharge on the portion of their income above $500,000 for individuals and $1 million for couples to help make health insurance affordable for small businesses and the middle class.
- According to the nonpartisan Joint Committee on Taxation, 98.8% of small business owners would not be subject to the health care surcharge, because they do not have enough income.
- The bill includes certain other revenue raisers, such as an excise tax on the medical device industry which will be offset by the newly insured using their products, raising $20 billion over 10 years.

VII. CONTROLLING HEALTH CARE COSTS OVER THE LONG-TERM

According to the nonpartisan CBO, the bill not only reduces the deficit over the next 10 years, it also is likely to reduce the deficit over the long-term, in the following 10 years. The bill will put downward pressure on health care costs over the long-term in numerous ways, as outlined below.

- PAYING FOR QUALITY OF CARE, NOT QUANTITY. Today's payment systems reward health care providers for delivering more care rather than better care, which drives up costs for everyone. This bill takes a number of steps to begin tying reimbursements to quality, not quantity, which will save money and improve quality by discouraging inappropriate treatments.
- FOSTERING CARE COORDINATION AND PROVIDER COLLABORATION. When providers are able to work together across different settings, like doctors' offices, hospitals, nursing homes and rehabilitation facilities, data show patients get well sooner and costs in the system are lower. The bill creates payment incentives for chronic care management and collaboration among doctors and facilities.
- PROMOTING PRIMARY CARE. Primary care providers can provide lower cost and higher quality more personalized care for many ailments. Despite their critical function, primary care doctors are undervalued in our current system, leading to a shortage. Our reform promotes primary care, including by increasing Medicare and Medicaid reimbursements to primary care doctors.
- INVESTING IN PREVENTION AND WELLNESS. Today, our health care system focuses on treating sickness, instead of promoting wellness. Focusing on prevention will save money by allowing patients and doctors to detect and address health problems early when they are easier and less expensive to treat. The bill also invests in wellness, eliminating co-pays for preventive services in Medicare and private plans, and establishing an employer wellness grant program.
- PREVENTING WASTE, FRAUD AND ABUSE. The bill provides new tools to combat waste, fraud and abuse within the entire health care system. For example, within Medicare, new authorities are provided to allow for pre-enrollment screening of providers and suppliers and permit designation of certain areas as being at elevated risk of fraud to put in place enhanced oversight.